Medical history questionnaire

INSTRUCTIONS

1. It is assumed that the patient is completing this form. If you are completing this form on behalf of the patient please read all references to "You" as referring to the patient in question.
2. This form has multiple sections that need to be filled in. Please r eview and answer all relevant sections and questions and u se free text boxes for details and additional information.
3. If uncertain about any of the questions or requiring assistance, please discuss with your carer, medical doctor, or dental clinician
4. If you have multiple medical conditions, medications or have a complex medical status; please obtain a medical history and medications list from y our attending doctor or specialist.
5. A New Medical history questionnaire is required for every new course of care, annually or when there is a significant change.
6. Medical History Questionnaire will be checked and confirmed at every visit, so please update your dental clinician if any changes.

☑ **I understand that if I am not able to complete this medical history I will need to provide a medical history prior to the dental appointment or it will delay the appointment or any treatment necessary. Please see your GP or medical specialist to get a printed copy of your medical history.** *

☑ **I have reviewed and understand my Rights and Responsibilities as outlined on the DHSV website** *

Your Profile (The Patient)

Title *
MS

First Name *
Bree

Last Name *
Johns

Date of Birth *
01/01/1988

Telephone

Mobile

e-mail address
confirmation of your submission will be sent to this email address

Address *
720 Swanston Street, Carlton VIC, Australia

Do you identify as Aboriginal or torres straits islander?
○ Yes ◉ No ○ Prefer not to say

You (the patient) can give self consent to the treatment and care? *
◉ Yes
○ No
○ Uncertain

Next of kin/family/carer whom we can contact if necessary
Full name, relationship to patient and contact details

Who is filling in this medical history questionnaire? *
◉ myself (the patient)
○ parent or family member

- ( ) patient with the assistance of the treating dental clinician
- ( ) other

Name and contact details (address/phone number) of main dental practitioner (if not in RDHM)

Name and contact details (address/phone number) of main medical practitioner (GP)

Mr Jason Wu
188 Royal Parade, Parkville

Name and contact details of any additional medical practitioner or specialist involved in your care in the last 5 years.

Are you currently linked in with external support service or support worker *
( ) Yes (•) No ( ) Uncertain

Are you able to provide a Medical history from your medical practitioner to bring to next appointment. *
(•) Yes ( ) No ( ) Uncertain

Scanned Medical History

Browse

Please upload a scanned copy of the medical history in the following file format. pdf, jpg, jpeg, docx, doc, png

Do you consent to provding access to MyHealthRecords.
(•) Yes ( ) No

Medical History Questions

Patient Height (cm) *
174

Patient Weight (kg) *
75

BMI
35.87

Are you at risk of falling down, or have you had a fall in the last 28 days? *
( ) Yes (•) No ( ) Uncertain
instability when walking or moving

Currently pregnant or breastfeeding? *
( ) Yes (•) No ( ) Uncertain

Have you had a splenectomy? (removal of entire spleen) *
( ) Yes (•) No ( ) Uncertain

Are you currently undergoing, or have previously undergone head and neck Radiotherapy treatment? *
( ) Yes (•) No ( ) Uncertain

Are you currenlty undergoing or have previously undergone Chemotherapy or other cancer treatment? *
( ) Yes (•) No ( ) Uncertain

Have you had previous complications receiving dental treatment? *

- ( ) Yes
- (•) No
- ( ) Uncertain

Are your immunizations up to date? (especially for children) *

- (•) Yes
- ( ) No
- ( ) Uncertain

Have you had HPV (Human Papilloma Virus) Vaccine? *

- (•) Yes
- ( ) No
- ( ) Uncertain

Do you have any additional or special needs or require additional assistance/support in any way? *

- ( ) Yes
- (•) No
- ( ) Not Applicable

(for children), Any exposure in the last 3 weeks, or currently have measles, chicken pox, rheumatic fever, or any other infectious disease.

- ( ) Yes
- (•) No
- ( ) Not Applicable

Do you have any current, ongoing or previous medical conditions or concerns in the following areas? (Cardiovascular AND Respiratory)

- Congenital heart disease
- Blood pressure
- Heart failure
- Irregular heartbeat/ Heart murmur
- Chest pains/ angina
- myocardial infarction
- Heart valve problems/ Heart valve replacement
- Circulation issues/ Swelling of ankles
- Previous Endocarditis
- pacemaker
- shortness of breath
- emphysema / COAD
- wheeze/chronic bronchitis/asthma
- pneumonia
- Sleep apnoea / Using CPAP/ snoring or stops breathing during sleep.
- lung problems needing hospital attendance
- Other

Cardiovascular AND Respiratory *

- (•) Yes
- ( ) No

Community Acquired Pneumonia 2018

Do you have any current, ongoing or previous medical conditions or concerns in the following areas? (Endocrine, Hepatic and haematological)

- Thyroid
- Diabetes
- Other Metabolic
- Abnormal liver function
- Jaundice
- Hepatitis
- Cirrhosis
- Liver failure
- Bruising/ Excessive bleeding in self or family member
- blood clots or bleeding disorders with self or family

member
- Anaemia
- Previous blood transfusions
- HIV/AIDS or other blood-borne diseases
- Other

Endocrine, Hepatic and haematological *

- ( ) Yes
- (•) No

Do you have any current, ongoing or previous medical conditions or concerns in the following areas? (Musculoskeletal and Nervous systems)

- Osteoarthritis
- Rheumatoid arthritis
- Backaches/sciatica
- Neck problems
- difficulty opening mouth
- Muscle related illnesses
- Joint problems
- Artificial prosthesis
- chronic pain
- MigrainesDizziness
- Leg or arm weakness
- Stroke
- seizures/epilepsy/fits/Febrile convulsions
- delirium, blackouts or fainting
- other

Musculoskeletal and Nervous systems *

- ( ) Yes
- (•) No

Do you have any current, ongoing or previous medical conditions or concerns in the following areas? (Gastrointestinal and genitoUrinary)

- Irritable bowel, Coeliac disease,Ulcerative colitis, Crohn's disease
- Nausea/vomiting/appetite loss
- Indigestion/Heartburn/reflux/hiatus hernia
- gastric ulcers
- Kidney/bladder infections
- On dialysis
- Kidney Transplants
- other

Gastrointestinal and genitoUrinary *

- ( ) Yes
- (•) No

Do you have any current, ongoing or previous medical conditions or concerns in the following areas? (Sensory, cognitive, neuropsychiatric, and other)

- Sensory
- Intellectual impairment
- Difficulty communicating
- Physical impairment
- Cerebral palsy
- Downs syndrome
- Dementia
- Schizophrenia / psychosis

- Depression
- Panic attack and anxiety
- Attention deficit disorders
- Intellectual and cognitive impairment
- Autism spectrum disorder
- Other

Sensory, cognitive, neuropsychiatric, and other *

- [x] Yes — Anxiety
- [ ] No

Other not previously mentioned or included.

Any other condition that is not mentioned? *

- [ ] Yes
- [x] No
- [ ] uncertain

eg poor teeth, recent prednisolone, other transplants

Any other condition that runs in the family? *

- [ ] Yes
- [x] No
- [ ] uncertain

eg thalassemia, muscular dystrophy

Do you have any of the following allergies or adverse drug reactions?

- Medications – antibiotics
- Medications - anaesthetics
- Other medications
- Latex/rubber products/gloves
- Tapes
- Antiseptics
- Food
- Other substances
- Blood relatives with relevant allergies or adverse drug reactions of interest

Allergies and adverse drug reactions *

- [x] Yes — Penicillian
- [ ] No

List any medication that you are currently taking? (including medications if they may be of dental interest / concern)

Medication (1)	Route	Frequency. dose, duration , reason
Lexapro	oral	20 mg x 1 daily

Medication (2)	Route	Frequency. dose, duration , reason

Medication (3)	Route	Frequency. dose, duration , reason

Medication (4) | Route | Frequency. dose, duration , reason

Medication (5) | Route | Frequency. dose, duration , reason

List other Medication(s) including vitamins, herbal remedies, over the counter

If you have a complex medications list, please obtain a copy from your GP or pharmacist.

Do you take anticoagulants and /or antiplatelets? *
- ○ Yes
- ◉ No
- ○ Uncertain

Do you take Corticosteroids/Steroids? *
- ○ Yes
- ◉ No
- ○ Uncertain

Do you take, or have taken Bisphosphonates and/or other anti-resorbtive injections or medications? *
- ○ Yes
- ◉ No
- ○ Uncertain

Have you previously, or currently require prophylactic antibiotics? *
- ○ Yes
- ◉ No
- ○ Uncertain

Social & Lifestyle

Do you smoke?
- ○ Yes
- ◉ Never
- ○ I have given up

Do you chew tobacco or betel nut?
- ○ Yes
- ◉ Never
- ○ I have given up

also known as areca nut, paan, supari, bin lang, puwak

Do you drink alcohol?
- ○ Yes
- ◉ Never
- ○ I have given up

Living situation (if patient is an adult 18+)

House

Or

Living situation (if patient is a child)

Do you live

With immediate family

Other housing issues

- [ ] Social isolation
- [ ] Stressful home environment
- [ ] Housing stress
- [ ] Poor access to transport
- [ ] Other
- [ ] Prefer not to say

Discrimination

- [ ] Religious
- [ ] Racial
- [ ] Gender
- [ ] Sexual orientation
- [ ] Gender identity
- [ ] Social isolation or exclusion
- [ ] Other
- [ ] Prefer not to say

Other stressors

- [ ] Poverty
- [ ] Low income
- [ ] Working conditions
- [ ] Insecure employment
- [ ] Work stress
- [ ] Unpaid carer
- [ ] Personal debt
- [ ] Other
- [ ] Prefer not to say

Legal / Justice

- [ ] Current incarceration
- [ ] Current legal proceedings
- [ ] Previous contact with the justice system
- [ ] Other Legal / Justice issues
- [ ] Prefer not to say

Substance abuse & addictions

- [ ] Alcohol
- [ ] Prescription drugs
- [ ] Non-prescription medications (eg OTC cough and cold medication)
- [ ] Illicit substances, ice(crystal meth)
- [ ] Gambling
- [ ] Internet/social media

Do any of your family / friends battle with an addiction issue(s)?

- ( ) Yes
- (X) No
- ( ) Prefer not to say

Trauma experience

- [ ] Torture
- [ ] Sexual assault
- [ ] Child abuse or neglect
- [ ] Elder abuse or neglect
- [ ] War or armed conflict
- [ ] Crime victim
- [ ] Other forms of violence or abuse
- [ ] Prefer not to say

General Anesthesia & Dental Surgical Unit

Have you been hospitalized for any health problems including previous surgery or general anesthesia? *

No

Have you had any complications with previous treatment, surgery or General anaesthesia? *

No

Have you had any close relatives with complications or problems with general anaesthesia? *

No

(If the patient is a child) were they born prematurely?

- ( ) Yes
- ( ) No
- ( ) Uncertain

Please indicate how far you can walk without stopping AND no chest pain or shortness of breath? (a flight of steps is approximately 6 steps) *

more than 2 flights

Do you have, Rashes, Pressure ulcers, wounds, dressings *

No

Do yo have mobility issues? *

No

Do you have the ability to walk without stopping? *

Yes

Do you have breathing issues? *

No

Do you have a "not for recescitation order" in place? *

- (•) Yes
- ( ) No

Please upload a copy of the order *

Browse

Please upload a document in the following file format: pdf, jpg, jpeg, docx, doc, png

Has a doctor ordered medical tests or examinations in the last year? *

- ( ) Yes
- (•) No

Any additional information that could be relevant? *

- ( ) Yes
- (•) No

Patient consent

The authorised entity to sign

Patient, parent, guardian, medical treatment decision maker

I confirm that the answers that I have provided to be correct. If under 18 years of age, then parent or guardian to sign. *

Signatory - Mobile number *

+61438354159

Send code

By validating this mobile number, we are confirming the identity of the authorised entity providing consent.